of the bundle, to $57k in switching probiotics, and to $18k with initiation of a probiotic policy.

Conclusion. Implementing a bundle of concurrent infection prevention strategies resulted in a significant reduction in CDI incidence. Refinements to the bundle led to significant reductions in CDI incidence, along with switching the type of probiotic, and delegating ordering authority to pharmacists to ensure probiotic compliance. Cumulatively, there was a 95% decrease in CDI incidence at the Long-Term Care facility and meaningful cost savings with each refinement.

Table 1. Observed facility-onset *C. difficile* infections (CDI) and associated costs for each time period at the Long-Term Care facility at Sharp Coronado Hospital from July 2008 through December 2018.

		CDI rate[1]	P-value of CDI rate changes	CDI Cases	CDI Recurrent cases	Patient -days	Abx DOT /1000 Pt-days[2]	CDI-related costs, annual	Probiotic cost, annual	Net costs, annual[3]	Change, annual cost
Initial	2008-2009	7.6		49	113%	64212	*	$ 213,717		$ 213,717	
Phase I	2010-2011	2.8	0.028	23	77%	80939	90	$ 146,755	$ 14,157	$ 160,912	-$ 52,805
Phase II, switch to Bio-K+	2012-Q3 2016	0.91	0.0015	16	14%	175382	54	$ 47,483	$ 9,252	$ 56,735	-$104,177
Phase III, Probiotic policy	Q4 2016 -2018	0.24	0.047	2	0%	80183	79	$ 7,736	$ 9,888	$ 17,625	-$ 39,110

[1]rate per 10000 patient days
[2]Abx DOT/1000 Pt-days - Antibiotic Days of Therapy per 1000 patient days
[3]Includes annual costs from CDI cases + probiotic purchases
* Data not available for this time period.

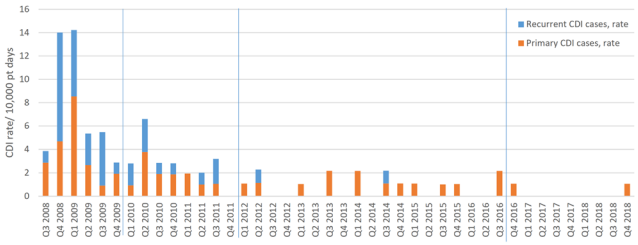

Figure 1: Quarterly incidence of C. difficile infection at the Long-Term Care facility at Sharp Coronado Hospital from July 2008 through December 2018. Incidence is reported in the number of cases per 10,000 patient-days, orange for primary CDI cases, blue for recurrent CDI cases. Different phases of the infection prevention strategy are demarcated with a vertical line.

Disclosures. **All authors:** No reported disclosures.

2447. Impact of Agency-Level Policies and Priorities upon Infection Prevention and Control in the Home Environment: Perspectives of Home Health Staff

Ashley Chastain, MPH[1]; Monika Pogorzelska-Maziarz, PhD, MPH, CIC[2]; Patricia Stone, PhD, FAAN[1]; Jingjing Shang, PhD, RN[1]; [1]Columbia University School of Nursing, New York, New York; [2]Thomas Jefferson University, Philadelphia, Pennsylvania

Session: 256. HAI: Miscellaneous
Saturday, October 5, 2019: 12:15 PM

Background. Infection prevention and control (IPC) is becoming a national priority in home healthcare (HHC) industry. However, little is known about the impact of agency-level policies and priorities upon IPC practices in the home environment. This qualitative study aimed to explore: 1) how home health agencies (HHA) are implementing IPC policies, and 2) perspectives of HHC staff on agency-level IPC policies and priorities and how they impact patient care.

Methods. From March to November 2018, we recruited staff from HHAs across the United States to participate in in-depth, telephone interviews. HHAs were purposively sampled based on high or low Quality of Patient Care star rating and other agency characteristics from 2016 Provider of Services and Home Health Compare data. Interviews were conducted with 41 staff from 13 HHAs, including administrators, IPC and quality improvement personnel, registered nurses and home health aides. Interview guides were tailored toward the role of the interviewee. Interview transcripts were coded and themes were identified using content analysis.

Results. Themes included: 1) "Handwashing is our priority"; 2) Innovative approaches to care coordination and IPC; (3) Monitoring staff compliance; and, (4) Opportunities for improvement. Almost all HHC staff described that handwashing was a primary focus of IPC policies and staff education at their agencies. Some staff depicted creative ways that their agency was coordinating patient care among staff who were not always in the office, and also unique approaches to educating staff about IPC policies and practices. Administrators and managers explained the ways that they monitored staff compliance around IPC policies, while nurses and aides described how the monitoring reminded them about proper procedures. Finally, HHC staff mentioned various ways in which care coordination, staff education and compliance could be improved at their agencies; for example, more frequent supervisory visits were perceived as a way to improve compliance with agency policies and practices.

Conclusion. This study increases our understanding of the impact that agency-level IPC policies and practices have upon HHC staff and patient care, in addition to specific approaches to care coordination, staff education and compliance monitoring.

Disclosures. **All authors:** No reported disclosures.

2448. Clinical Presentation and Outcomes of Long-Term Care Residents with Coronavirus Respiratory Infection: A Retrospective Cohort Study

Victoria R. Williams, MPH CIC; Dariusz Pajak, BASc CIC; Natasha Salt, BSc BASc CIC; Jerome A. Leis, MD MSc FRCPC; Sunnybrook Health Sciences Centre, Toronto, ON, Canada

Session: 256. HAI: Miscellaneous
Saturday, October 5, 2019: 12:15 PM

Background. Human coronaviruses (CoVs) are a major cause of respiratory infection and institutional outbreaks, yet the epidemiology and clinical outcomes of these viruses is poorly described among the elderly residing in long-term care facilities (LTCFs).

Methods. We performed a retrospective cohort study of LTCF residents with positive nasopharyngeal or mid-turbinate swabs for CoVs (OC43, 229E, NL63 and HKU1) between January 2013 and December 2018. Demographic and clinical data were obtained from resident charts including clinical presentation, treatment, outcome, and transmission to other residents. Variables were compared using univariate analysis.

Results. 3268 residents met inclusion criteria (median age 93 years, 90% male) comprising 7.5% (246/3268) of all positive respiratory virus specimens detected during the study period. 97(39%) of cases were associated with a respiratory outbreak while 149(61%) were sporadic cases that did not result in transmission. OC43 (52%) was the most commonly identified CoV and was more commonly associated with outbreak cases (76% vs. 37%; $P < 0.001$). In total, 87% of all cases had two or more of runny nose/congestion, cough, sore throat/hoarse voice or fever. The most common symptoms among residents were cough (85%), runny nose/congestion (79%), and sore throat/hoarse voice (59%) and only 17% of residents had a measured temperature of ≥ 37.8C. Only 6% of residents received antibiotic treatment for suspected secondary bacterial pneumonia. The 30-day mortality rate was 3.7% with 67% of deaths attributable to the CoV infection. There was no statistically significant difference in symptoms, treatment or outcomes associated with outbreaks or seasonality.

Conclusion. CoVs make up an important proportion of respiratory viral infections among LTCF residents and may result in frequent outbreaks. Most residents remain afebrile and have self-limited illness while only a small minority develop secondary bacterial pneumonia and death. Given these findings the benefits of control measures should be weighed against the impact on resident quality of life.

Disclosures. **All authors:** No reported disclosures.

2449. Early Detection of *Candida auris* is Essential to Control Spread: Four Effective Active Surveillance Strategies

Snigdha Vallabhaneni, MD, MPH[1]; Matthew Zahn, MD, MPH[2]; Erin Epson, MD[3]; Kathleen ODonnell, MPH[4]; Sam Horwich-Scholefield, MPH[5]; Richard Brooks, MD, MPH[1]; Elisabeth Vaeth, MPH[6]; Timothy Blood, MPH[6]; DJ Shannon, MPH, CIC[7]; Christine Feaster, MS, CIC[8]; Vivian Leung, MD[9]; Meghan Maloney, MPH[10]; Kaitlin Forsberg, MPH[11]; Alexander Kallen, MD[12]; Brendan R. Jackson, MD, MPH[12]; Maroya S. Walters, PhD[13]; [1]Centers for Disease Control and Prevention, Atlanta, Georgia; [2]Orange County Department of Health, Irvine, California; [3]California Department Of Public Health, Richmond, California; [4]CDPH/ OCHCA, Irvine, California; [5]California Department of Public Health, Richmond, California; [6]Maryland Department of Health, Baltimore, Maryland; [7]Eskenazi Health, Indianapolis, Indiana; [8]Indiana State Department of Health, Indianapolis, Indiana; [9]Connecticut Department of Public Health, Hartford, Connecticut, [10]Connecticut Department of Health, Hartford, Connecticut, [11]IHRC, Inc. and Centers for Disease Control and Prevention, Atlanta, Georgia, [12]CDC, Atlanta, Georgia, [13]Division of Healthcare Quality Promotion, Centers for Disease Control and Prevention, Atlanta, Georgia

Session: 256. HAI: Miscellaneous
Saturday, October 5, 2019: 12:15 PM

Background. *C. auris* has been identified from > 1600 US patients. Risk factors include high-acuity post-acute care admissions (e.g., long-term acute care hospitals (LTACHs)), hospitalization abroad, and carbapenemase-producing organism (CPO) colonization. Early detection of *C. auris* is key to controlling spread. We describe four active surveillance strategies that led to early *C. auris* identification.

Methods. Based on known risk factors, state health departments used active *C. auris* surveillance strategies: (1) species identification of yeast from urine cultures from LTACHs, (2) screening patients with a CPO and hospitalization abroad, (3) LTACH *C. auris* point prevalence surveys (PPS), or (4) admission screening in acute and long-term care settings.

Results. (1)A laboratory in Southern California serving 12 LTACHs began species identification for all *Candida* from urine cultures, which would have otherwise been discarded because they are assumed to be not clinically significant. Within 5 months, testing of 271 *Candida* urine isolates identified the region's first *C. auris* case, prompting contact tracing and identification of additional cases and facilities. (2) When CPOs were identified in patients with recent hospitalizations outside of the United States, the Maryland Department of Health screened patients for *C.auris* colonization. Of four screened, one, who received care in Kenya, was *C. auris* colonized. (3) The Indiana State Department of Health implemented monthly PPS at an LTACH that frequently admits patients transferred from a high prevalence area. Of 38 patients screened, two were colonized. (4) The Connecticut Department of Public Health offers *C. auris* admission screening for patients who received inpatient care in high prevalence areas; of 12 screened, one *C. auris* colonized patient was found. Infection control assessments and implementation of infection control measures followed each detection.

Conclusion. Early detection of *C. auris* is important but is impacted by infrequent yeast species identification and a reservoir of asymptomatic colonized patients. Healthcare facilities and public health jurisdictions can consider adopting one or more of these strategies based on epidemiology and resource availability.

Disclosures. **All authors:** No reported disclosures.